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‘It’s the little things that count’: health care professionals’ views on delivering dignified care:
a qualitative study

Abstract

Aims: To explore health care professionals' perspectives of dignified care and experiences of providing care.

Background: Although 'care' and dignity in care are seen as central to the delivery of good care by patients, families and professionals, we still lack a clear understanding of what these, often contested and elusive concepts, mean in the practice setting, particularly from the perspective of health care professionals.

Design: Interview based qualitative research design.

Methods: In-depth interviews were conducted with health care professionals working in four NHS trusts. Data were collected between June - November 2012. Interviews were audio-recorded, transcribed and analysed using thematic analysis.

Findings: 48 health care professionals took part in this interview based study. Two main themes that encapsulated how care and dignity in care is enacted by professionals were identified: focusing on the 'little' things that matter to both professionals and patients; and improving care by making poor care 'visible'.

Conclusion: Our findings show that the 'little things' in care allow professionals to 'care for' but also 'care about' patients, suggesting that these two aspects of caring become intrinsically interlinked. Our findings also suggest that 'making poor care visible' challenges engrained and task rather than human focused care in a non-threatening way, which can be the catalyst for providing care that is caring and dignified.

Keywords: nursing, health care professionals' perspectives, dignified care, caring, older people, qualitative methods, good care

SUMMARY STATEMENT

Why is this research or review needed?

- We know that patients and their families view dignity in care and a caring attitude by health care staff as crucially important to their care.
- However, care and dignity in care have been described as elusive and contested concepts.
- We need to understand health care professionals' understanding and perspectives of care and dignity and how these are enacted in practice.

What are the key findings?

- Nurses enact dignity in care by focusing on the 'little' things that matter to both patients and themselves in terms of their professional understanding of care.
- Making poor care 'visible' allows health care professionals to challenge breaches of dignified care in a non-threatening way and improve care.

How should the findings be used to influence policy/practice/research/education?

- Health care professionals should focus on such 'little' things as the 'big' things in providing dignified care that reflects caring 'for' and 'about' patients.
- As such, individualised care is more meaningful in enacting dignified care than processes such as 'red peg' initiatives.
- Managers in NHS settings should emphasise the importance of such 'little' things and provide staff with the resources to challenge poor care by making these situations 'visible' in a non-threatening way.

INTRODUCTION

In the UK health care context, one of the key policy goals of the last two decades has been around improving the quality of care. This debate has been led by a concern with the technical aspects of care delivery, such as optimal therapeutic regimes, the delivery of guideline and evidence-based care and an emphasis on targets as a mechanism for improving standards of care. Running in parallel with these initiatives has been the revelation of both the lack of good quality care and the lack of caring in how care is delivered to and experienced by vulnerable children and adults, both young and old, in a number of settings such as acute hospital wards (Tadd *et al.* 2011b) and long-term care homes (Manthorpe 2014). Whilst such features are not unique to the contemporary health care context, the ‘failure’ of health and social care staff to deliver care, that is of good quality in terms of standard, evidence base and effectiveness and dignified in the way that respects the individual, has received considerable attention in the press and has been at the heart of several recent public enquiries in the UK (Francis Inquiry into Mid Staffordshire NHS Foundation Trust, Winterbourne View Panorama Investigation). This has generated a stream of national and local policy initiatives and interventions and service developments to specifically promote the delivery of dignified care.

Research across a range of countries and care settings has consistently demonstrated that older people and their relatives ascribe great importance to how the care they receive is delivered by health and social care professionals (Oosterveld-Vlug *et al.* 2013, Attree 2001, Anderberg *et al.* 2007, Lothian & Philp 2001, Tadd *et al.* 2011a). Patients consistently report that they expect individualised, patient centred care delivered through a caring relationship between staff and patients where patients’ and their families’ views are considered and integrated into care (Woolhead *et al.* 2006, Attree 2001).

Background

Defining what constitutes care and caring is both conceptually complex and equally as elusive and contested as defining dignity/dignified care delivery (Pearcey 2010). One helpful distinction is that characterised by Pearcey (2010) as caring for, the delivery of ‘hands’ on care and ‘caring about’, which is focused around social and emotional support. ‘Caring for’ is central to the delivery of health care and particularly in nursing practice, where ‘care’ is central to the profession (Gastmans 2013). Research exploring professionals’ perspectives on dignity in care suggest that maintaining dignity plays an important role in providing care (Baillie 2009, Hall & Høy 2012, Cairns *et al.* 2013, Ariño-Blasco *et al.* 2005). ‘Caring’ has been described as being part of ‘good care’ (Pearcey, 2010) and the delivery of dignified care is also often associated with ‘good care’ provision (Anderberg *et al.* 2007, Attree 2001). Research exploring the patient perspectives of ‘good’ care has characterised this as individualised, patient focused care and humanistically provided through the presence of a caring relationship by staff (Attree 2001). These themes are not dissimilar to the key features of dignified care from the patient perspective noted above. Although we now have a better understanding on health care professionals’ perspectives on ‘good’ care and dignified care, there is still a lack of research exploring how health care professionals enact such ‘good’ and dignified care in practice. The aim of this paper is to shed further light on what constitutes ‘good’ care from the professional’s perspective and how this may be enacted in practice.

THE STUDY

Aims

The aims of the research were to explore health and social professionals' perspectives of dignity in care of older people, including aspects that facilitate and hinder the delivery of dignified care.

Design

The data presented here were collected as part of a larger, mixed methods research project exploring the professional perspective of dignity in care of older people and the overall research methodology has been described elsewhere (Cairns *et al.* 2013, Kinnear *et al.* 2014). Mixed method research is not linked to a single world view paradigm, since it strives for an integration of qualitative and quantitative research methods to explore the area of interest and thus does not comfortably sit within a positivist or constructivist perspective (Feilzer 2010). A mixed method research design has been described as sitting within different perspectives, dependent on the underlying rationale for mixing qualitative and quantitative methods (Creswell 2013, Creswell & Tashakkori 2007). Our study used a 'complimentary' approach to a mixed method design (Greene *et al.* 1989) to reveal different dimensions of dignity and enrich understandings of this concept.

Participants

Participants were recruited from four NHS trusts, which were chosen to reflect the different contexts where older patients experience ward based care: a community trust providing long-term care, a community trust providing specialist mental health care for older people and two acute trusts providing specialist and acute care for older people. In these four trusts we aimed to recruit a maximum variation sample in terms of age, gender, job role (ranging from junior members of staff to senior/specialist roles), experience and area of work and invited health

and social care staff to take part in our research study by sending information leaflets via ward clerks and secretaries. We aimed for 10-15 participants per trust to ensure we would have a balance of participants from each trust and a varied group of participants in terms of professional identity, seniority and gender/age in each trust.

Data collection

This paper is based on the interview data collected with health care professionals caring for and working with older people in four NHS Trusts (mental health, acute sector and community care). All data were collected through in-depth interviews (please refer to appendix 1 for the interview guide) and after consent was obtained were audio-recorded and transcribed. Data were collected between June - November 2012.

Ethical considerations

Ethical approval for the study was obtained (REC ref number: 10/H0711/49) from both Brunel University and the UK National Research Ethics Service (NRES). All participants gave written consent to take part in the interviews. On two occasions, the participant did not give consent to have the interview audio taped. In this case the researcher (DK) took notes which were written up immediately after the interview. All participants were reassured that their interview data would remain anonymous (including the trust they worked for) as some wanted to express concern about undignified care delivered in their current role. In addition, for some participants it was upsetting to recall negative experiences of care witnessed. However, our researchers handled these situations in a sensitive manner by stopping the interview and only proceeding when participants assured the researcher that they were happy to continue.

Data analysis

The qualitative data were managed using NVivo10 and analysed thematically (Braun & Clarke 2006). The process of thematic analysis involved analysing transcripts, which were read several times. Codes were created to sum up what a particular section of text conveyed and these were then collated to form common themes, whilst searching for negative cases (i.e. identifying experiences which did not fit the coding framework) (Burnard *et al.* 2008). Each theme was then explored in turn to understand the full experience. Transcripts were reviewed and coded to determine key themes emerging from these data in relation to our research questions.

Rigour

In line with agreed guidelines for rigour in qualitative research, we included steps during the analytical process to ensure trustworthy, credibility and transparency (Mays & Pope 1995, Long & Johnson 2000). These included double coding by two experienced qualitative researchers, audit trail of coding framework and subsequent steps of analysis and researchers maintaining reflexivity throughout this process. The process of coding was initially carried out by the research fellow (DK). A sub-set of the interviews and focus groups were analysed by a second researcher (VW). The coding framework and identified themes were discussed at regular team analytical meetings thus ensuring group validation of the emerging themes, as well as discussing researchers' reflections on the analysis process. Each theme or category was verified by searching through the data for comparisons and challenges so that the themes could be refined and all the data accounted for. The concept of what constitutes 'good' care giving was initially identified during analysis. This was then further explored during a

secondary analysis process to fully understand the professionals' (predominately nursing) perspective of what constitutes 'good' care and how this is enacted in practice.

FINDINGS

Participant details

A total of 48 health care professionals took part in in-depth interviews. The majority of participants were female (N = 45) and their age ranged from 20 – 56 (mean age 41) years. Participant job roles included: nursing role (N = 16), occupational therapy or physiotherapy role (OTs) (N = 19) and managers (N = 5). The remaining eight participants included one each of a diverse range of roles (e.g. clinical psychologist, radiographer and psychiatrist). Four of these participants included roles in their trust that are unique and again not mentioned to ensure patient anonymity.

Staff experiences of providing dignified care

This project focused on identifying professionals' perspectives of dignified care, in particular its barriers and facilitators. These findings have been reported elsewhere (Cairns *et al*, 2013; Kinnear *et al* 2014). As part of this, we also tried to understand the factors that supported the development of dignified care in practice, that were more transient and subtle than merely focusing on the more prominent issues of the organisational and environmental contexts. We therefore actively sought out from participants, examples of good practice in supporting and delivering dignified care in their everyday practice. The interviews produced a number of examples where dignified care was given or witnessed. Two main themes were identified from participants' stories that related to enacting dignified care and providing good care: the

‘little’ things’ that matter to both patients and staff and ‘making poor care visible’ to reflect, challenge and improve care.

The ‘Little’ Things

From the perspective of our participants it was in the ‘little’ things in how staff and patients interacted that dignified care was revealed. Louise, a community staff nurse illustrates this in the following example:

a lady who was dying a few weeks ago and her carers, every day, sounds really silly, they bought her a packet of chocolate buttons, because she loved dairy milk and she wasn’t eating, but every day they would just give her these buttons that would melt on her tongue and they were buying that out of their own pocket. So you know, you get good things and you get bad things.

Similarly, Karen, a deputy head of nursing, recounted a story where she had witnessed a care situation which she deemed as dignified care on a ward round on a general medical ward in an acute hospital:

And one of the things that I use as an example...there was a nurse who was behind the curtains with a patient and you could hear from what was going on, there was obviously a wash going on, ...the nurse said it is, you know, is that too much soap and would you like me to ... soap your feet and the patient said... I’ve never, never had that done since I’ve been here, ooh that would be lovely. And the nurse saying let me go and top up the water because this has gone a bit cold. It was just the extra care and consideration that was shown to the patient and when the nurse went to leave from the curtains, she said, now I’m just going to be outside, I won’t be long. I’m just going to

get the water and then I'll be back. Are you warm enough? Are you okay as you are like that for a minute? So it was just attention to detail

Another 'little' thing that was deemed crucial was for staff to introduce themselves properly and respect the space patients occupied (ie their bed within curtains) as private space, as Anna a nurse-practitioner on a trauma unit explained:

I think it's when the nurses go in or the doctors actually for that matter and they actually introduce themselves by name. And make sure they do that. And the other thing is and certainly that's much improved now, is the doctors are much better these days. And probably over the last year I would say at making, when the curtains are drawn round a patient they just don't go bowling in there, they always stop and ask, 'Can I come in?'

This notion of 'basic' good manners of introducing oneself by name to patients seemed to include a personal element, which if it was missing lead to care where '...there was nothing, other than a task being done' as Karen, a deputy head of nursing of an acute trust stated and this could ultimately comprise dignified care. Interpersonal behaviour such as introducing oneself by name to patients, which could be deemed a small, insignificant thing in a busy, acute clinical environment, has recently also received increased (social) media attention through twitter campaigns such as #mynameis campaign by Dr Kate Granger, a medical registrar in geriatric medicine and cancer patient. She is actively promoting and highlighting the importance of health care professionals to introduce themselves to patients through teaching, talks and social media campaigns such as twitter and blogs.

Maggi a nurse specialist, who discharged an older patient from an acute ward to a nursing home, explained how such little things give humanity to nursing care. She described how at

the nursing home the patient had her hair washed and styled the way she wanted, which appears like a 'little' thing but was meaningful, dignified care for the patient and her family:

Yes, I sent one of my patients from a ward here, I won't name the ward and I sent her to [a] Nursing Home and on arrival the nurses ... asked her would she like a bath and her hair washing and ... they made her hair look like it had always looked, they groomed it for her. And I got a phone call from her daughter saying she thought she was in heaven when she went there. Because you know, she was treated like a human being. And she died and the family have written to say how wonderful the care was, what a relief it was for them when she went in there, how kind everyone was.

The focus of these data extracts was the little things that mattered to patients, such as providing little chocolates to cheer someone up, making sure patients felt at ease and comfortable when providing personal care by talking to them, ensuring the water is at the right temperature and the care provided was how the patient preferred it as well as introducing oneself by name when first meeting a patient. As such, the 'little' things important to patients included personalised patient centred care, empathy and attention to both patients' needs and their environment. However these 'little' things were often the 'big' things that mattered and interestingly, although staff talked about initiatives implemented by the various Trusts to improve dignity in care (such as red pegs, coloured food trays etc) those did not feature when stories of dignified care were retold.

Making Poor Care Visible

Everyday routines that have become so engrained into the daily work and physical ward surroundings that are no longer being noticed, appear to contribute to acceptance of poor care as such practices become invisible. These included patients being routinely put in

incontinence pads regardless of need, talking over the patient, carrying out clinical care without explanation. These examples of poor care were not described as ‘purposeful’ poor or undignified care giving but rather as ‘unnoticed’ care giving, whereby certain care routines had become so engrained, task orientated and habitual that they went unnoticed by staff. This also included poor physical care settings which could potentially lead to undignified care. These poor care situations were often so invisible that staff who had worked in these care settings for a long time, had simply stopped noticing. The following story shows how making poor care visible can have a powerful impact on staff, care and the care environment.

Linda who was a nurse consultant for older people in an acute NHS Trust and had worked in her current post for several years, wanted to raise staff awareness around meal times, an important issue raised repeatedly in patient surveys and why staff were reluctant to implement recent ward changes which asked for patients to be taken to a dining room for meal times. She decided to film how staff behaved on a general acute ward that mainly admitted older people. The film was shown to the ward staff afterwards. The staff were so shocked by how the ward was currently run in particular in relation to meal times that they decided to use the dining room so patients could share their meals together at a large table away from their very clinical bed space that was often used for toileting and bathing. The result was a very different film shown to staff after the change was implemented:

And the film kind of showed this in all its glory... It showed nobody talking to each other. And then when we started using the dining room and we got patients really involved, ... we cook the toast fresh as they ordered it. So the smell was amazing on the ward, because it was just you know, in the dining room. .. our bread order went up by two or three loaves within a week, because people were eating more for breakfast because they were hungry and ..., people were helping each other. They were

drinking more because they were pouring each other tea. They were doing normal things like spreading their own marmalade, because of course, if you've got a table with five or six people you can give them it and they do themselves. ... the noise level was amazing on this film, because they were talking to each other. So they were giving each other advice about how to get over their illness or their disability.

This example shows that staff themselves identified an area where breaches in dignified care could or did happen as the daily routines and physical environment were simply accepted and potentially undignified care situations had become invisible. The film provided a means of making these care situations visible and in turn raised awareness amongst staff to change their practice and physical environment to improve patient care, thus creating a model of 'improved care'.

On a more individual level, staff also explained how they made poor care visible to others by confronting engrained and habituated behaviours. Karen, a deputy head of nursing, shared her experience of making poor care visible by talking about it with staff:

... I think on occasions when you might see something or hear something and you point it out, my observation would be, that people respond in what I would say is an appropriate manner. So as an example, ... there was a porter who was wheeling a patient ... But it was, the corridor was fairly chilly and it was an elderly gent and he was in a gown and he did have a blanket over his legs, but the bottom of his legs were bare and he had bare feet. And I did, I stopped the porter ..and said, I said, 'Oh I wonder whether this gentleman has got some slippers.' And he kind of looked a bit taken aback and ... And I said, 'Oh shall we just make sure he's well tucked in.

Caroline, a nurse consultant in an acute hospital also described how she would deal with poor care, such as leaving a patient exposed when giving them a bed bath and make such undignified care visible and noted by her colleagues:

After I've usually covered them [patient] up, then I would raise that concern... I'd explain to the nurse who was dealing with the patient. If it's an untrained nurse, then I would explain what I've just done, but I would pick that up. ...we do have conversations about this on a regular basis at more senior level. And again it's all very well having those conversations at senior level if we've had a complaint in, but unless you actually do something at clinical practice level, you're not going to change anybody's understanding of why you've just done that.

She clearly highlights the importance of making poor care visible at the 'grass roots' ie where such care is happening rather than having discussions on a more removed level such as senior meetings.

It is important to note that these stories share two common features: the person making potentially undignified care visible tended to be a senior member of staff, thus suggesting it may be easier to raise awareness or confront such issues if you are an experienced, senior member of staff, as Lucy, an OT assistant explained: 'I feel confident enough to say that they're [patient] still waiting [to be taken to the toilet], but I wouldn't feel confident enough to reprimand someone for it. ... it's quite nerve wracking to go and say to a senior colleague this person is still waiting.'

Additionally, the way such situations were approached was crucial; rather than making the involved colleagues feel challenged or criticised, situations were made 'visible' in a respectful and non-judgmental way, with the aim to change, educate and improve practice rather than blame someone for poor care.

DISCUSSION

This paper reports on two aspects that were identified as important to professionals in providing 'good' dignified care to older people. Focusing on the 'little things', which could occur during hands on care providing for hygiene needs, interpersonal behaviour and communication and providing patient centred care, allowed professionals to show they 'cared', something which appears central to caring. Yet it has been argued that care-giving and 'caring' is being undermined by an increasingly market driven health service where 'maximising efficiency has come to mute the moral, emotional, religious and aesthetic expressions of patients and caregivers' (Kleinman 2012)p. 1550).

Providing the little things that matter to patients requires time to listen, sensitivity, empathy and concern, which as Kleinman (2012) argues are increasingly getting lost in health care systems that focus on technological advancements, efficiency and economic rationality. 'Time' is a resource that is increasingly being neglected as part of providing good, dignified care in busy, understaffed care environments. This is also reflected in previous literature about patients' and their families' perspectives of care where good care has been characterised as nurses engaging with them, providing the 'little things' that matter and on the opposite spectrum, 'little time' for patients was a main reason for poor care experienced (Attree 2001). The centrality of such 'little' things as part of care is supported by research exploring nurses' views on dominant values in clinical nursing work, where participants felt that due to time constraints they were unable to provide patients with the little things that mattered, affecting the care they received. The importance of the 'little things' in providing good care, particularly in nursing, has been emphasised for a considerable time, with

MacLeod (MacLeod 1994) arguing that it those little things that make a difference to patients and not only reflect caring and compassion but are imbued with nursing skill and knowledge as such ‘little things’ allow nurses to fully provide patient centred care, that is dignified, tailored to the patients’ physical and emotional needs and promotes well-being and recovery. More recently, research exploring the patient experience of respect and dignity in a mental health care setting also highlights the ‘significance of small things for experiencing dignity’ (Skorpen *et al.* 2014), p.5).

It seems the ‘little things’, despite being valued by both patients (Attree 2001, Skorpen *et al.* 2014) and staff as pivotal to providing good, dignified care, can easily be forgotten or overlooked since these are often subtle and unconscious. It is therefore not surprising that poor care often occurs when staff become over-familiar with their environment, lack the time to question practices and poor practices become engrained (Attree 2001, Pearcey 2010). The participants in our study revealed how making everyday practices visible through film, conversation and reflection enabled them to not only recognise care that was provided in a dignified way but more importantly highlighted areas where poor care had occurred on an everyday accepted practice. This was of particular importance compared with a ‘one-off’ incident which may have been recognised as poor care and thus potentially enacted on immediately, these poor care practices were no longer recognised as such as they had become engrained in daily practice. Making these situations visible through a film, photographs and open reflection, allowed participants to view and question these practices from a different point of view, recognise these as poor practice and change behaviours and external contributing factors accordingly. It is important to notice that this also allowed staff to see the positive impact of such changes rather than merely focusing on the negative. Similar approaches, which focus on making ‘invisible’ practices visible to change care and care

settings to more patient focused, dignity enabling environments have been adopted elsewhere, including mealtimes in hospital (Dickinson *et al.* 2007) and more recently through experience based co-design (Bate & Robert 2006).

Our research adds to existing knowledge by showing that, from the perspectives of staff, dignified care needs to be integrated into individualised, patient centred care and this may look different for different patients. We therefore need to include a wider understanding of what dignity means to patients and staff rather than merely focusing on protocols and procedures. Our data suggests that staff actively think about how such care is provided and integrated in their clinical everyday practice rather than purely focusing on practical aspects, such as colour coded trays and pegs on curtains around bed bays. Failings in dignified care are often related to engrained task-orientated practice that has become invisible to those who carry out such everyday tasks and through making these visible, they are able to reflect and improve their practice.

Limitations

Although we aimed to recruit a range of health care professionals in the four selected trusts, we were only able to recruit a very limited number of medical staff. This may have led to an increased focus on dignity in ‘hands on care’ since the majority of interview participants worked at ward level either as a nurse or therapist. While the majority of participants in our study were female, this reflects the general NHS nursing and therapy staff population.

CONCLUSION

Caring and dignified care are both elusive concepts, yet central to health care, particularly nursing where most care is undertaken as 'hands on care'. However, it is not clear how health professionals enact dignified care and 'care for' patients in health care settings. Our findings show that the importance of 'little things' in delivering dignified care for staff, as they not only allow them to 'care for' but also 'care about' patients. This would suggest that by providing the 'little things' to patients, 'caring for' and 'caring about' become intrinsically interlinked rather than being two separate aspects of care. In that sense, 'the little things' are the 'big things' and should receive increased focus in nurse education, practice settings and organisational management. Although we need to draw on theoretical and philosophical conceptualisations of 'caring' and 'dignity' to understand its theoretical underpinning and provide transferrable definitions of these complex concepts, it is also crucial that we provide health care professionals with concrete aspects of how they can improve their care and deliver dignified care in practice. Our findings suggest that a focus on the 'little things' can help professionals to enact such care and by 'making poor care visible' challenge engrained and task rather than human focused care in a non-threatening way, which can be the catalyst for providing care that is caring and dignified.

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